IN THE COURT OF COMMON PLEAS OF CUYAHOGA COUNTY, OHIO

CIVIL DIVISION

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Robert Paoloni, a minor, et al.,

Plaintiffs, :

vs. : Case No. 327020

Erast J. Haftkowycz, M.D., et al., :

Defendants. :

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DEPOSITION

of Philip T. Nowicki, M.D., a witness herein, called by the Plaintiffs under the applicable Rules of Civil Procedure, taken before me, Iris I. Munsell, a Notary Public in and for the State of Ohio, at the offices of Philip T. Nowicki, M.D., Children's Hospital, Wexner Institute, 700 Children's Drive, Columbus, Ohio, on Tuesday, July 21, 1998, at 1:00 p.m.

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ORIGINAL

APPEARANCES:

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On behalf of the Plaintiffs.

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On behalf of Defendant Dr. Haftkowycz.

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By Thomas H. Allison
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On behalf of Defendant Fairview Hospital.

- - -

Tuesday Afternoon Session,
July 21, 1998.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that the deposition of Philip T. Nowicki, M.D., a witness herein, called by the Plaintiffs under the applicable Rules of Civil Procedure, may be taken at this time by the Notary; that said deposition may be reduced to writing in stenotypy by the Notary, whose notes thereafter may be transcribed out of the presence of the witness; and that proof of the official character and qualification of the Notary is waived.

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PHILIP T. NOWICXI, M.D.

being by me first duly sworn, as hereinafter certified, deposes and says as follows:

EXAMINATION

By Mr. Lancione:

Q. Would you state your full name, please.

A. Phillip, with one L, Theodore Nowicki, N-o-w-i-c-k-i.

Q. Where do you reside, Doctor?

A. In Pickerington, Ohio.

Q. What's your address?

A. 4969 Wagonwood Drive in Pickerington.

Q. By whom are you employed?

A. By The Ohio State University and by the Pediatric Academic Association, which is the practice plan for the Department of Pediatrics at The Ohio State University.

Q. When did you first become involved as an expert witness in this case?

A. When I was contacted by Steve approximately six months ago.

Q. Do you have a date?

A. I have a letter someplace, but I don't have a date in my mind, no.

Q. Did you bring your file with you?

A. I don't have a file.

Q. Where would the letter be?

A. In my office. I can get it.

Q. Okay. Would you, please?

A. Sure.

Q. And any other document you might have in connection with your work in this case.

A. Okay.

(Off the record.)

A. I don't have it. I can't find it. We can find out when it was, I'm sure. What I have here is the report that I prepared and also the medical record of the child. That's what I've used.

Q. May I see those, please. Doctor, showing you what is marked Exhibit 1 for purposes of identification at this deposition. Doctor, the document I just handed to you, can you identify it, please.

(EXHIBIT MARKED FOR IDENTIFICATION.)

A. This is the report that I prepared for Steve Walters regarding this case on February 24, 1998.

Q. Is that the first and only written report that you prepared?

A. Yes, sir.

Q. Do you have any other written notes or memoranda of any kind in connection with your work here?

A. No.

Q. Has your deposition been taken before, Doctor?

A. Yes, sir.

Q. If you don't understand any of my questions, please ask me to clarify them before you answer. You have a tendency to start to answer the question before I'm finished, so please wait until I'm finished before you answer, okay?

A. Fine.

Q. These yellow note pad pages throughout the hospital record that I'm looking at, are those pages that you put in here?

A. Yes.

Q. And what was the purpose of that?

A. They represent portions of the medical records that highlight my testimony or my evidence regarding my testimony.

Q. Have you read any other documents other than the documents that are represented in this black folder?

A. Yes.

Q. What?

A. I have read the depositions of the nurses, Fawn Hoefke, Cathleen Hugney, Dr. Haftkowycz, Dr. Landon, Dr. Gimovsky, and I think that's it.

Q. Dr. O'Grady?

A. Yes.

Q. Dr. Nakon?

A. No, I have not seen that one. Oh, and the doctor from Louisiana.

MS. DISILVIO: Cline?

A. Cline, the neurosurgeon.

Q. Tell me about your experience in consulting as an expert in medical malpractice cases.

A. I have been working as a consultant for approximately the past seven years. I work for both Plaintiff and Defense, whoever calls. I have never advertised. I do about four to five cases a year. It's a very small percentage of my time.

Q. And I don't have your CV here, but your specialty is pediatrics?

A. I am a Professor of Pediatrics and Physiology at The Ohio State University. I am Board certified in pediatrics and also in neonatal/perinatal medicine. My clinical specialty is that of neonatology.

Q. And where do you practice that specialty?

A. At the present time, I practice that specialty primarily at University Hospital in the intensive care nursery here in Columbus, Ohio.

Q. And what are your present duties in some kind of time frame at the ICU at OSU?

A. I spend approximately 50 percent of my time in clinical work and the rest in research and teaching.

Q. Let me go back to my question. How much time do you spend in the intensive care unit at OSU?

A. I attend that nursery three months a year each July, December, and March. During that time I am the sole physician responsible for the unit. All admissions to the unit are my patients. I'm the only one there. I also cross-cover the nursery every other night and every other weekend throughout the entire year.

Q. And what does that mean?

A. That means that going roughly 5:00 in the afternoon through 7:00 the next morning on a weekday, or from 5:00 on Friday afternoon until 7:00 on Monday morning, I am responsible for those patients every other weekend, every other night.

Q. You're on call. You're not at the unit, correct?

A. 1 am on call, correct. But when I am on call, roughly half of the days I am on call I am called into the hospital.

Q. Now, other than the three months, what are your clinical responsibilities other than you've told me about in the ICU and the on-call responsibilities?

A. I have none.

Q. The rest of that is research?

A. And teaching.

Q. Didactic teaching?

A. My teaching is to second-year medical students in physiology, to third-year medical students in pediatrics, to fourth-year medical students in pediatrics, to pediatric residents in the field of neonatology, and to obstetrical residents in the fields of fetal physiology and fetal medicine.

Q. And where are those responsibilities fulfilled?

A. Primarily at University Hospital and at Children's Hospital here.

Q. And what time period do those responsibilities involve?

A. My primary responsibility is when I am on service, the three months that I am on service. However, I have teaching responsibilities year round. I attend conferences year round, and I'm expected to provide lectures for medical students year round.

Q. When and where do you do that?

A. I do that over on campus to the second-year medical students. I do that here at Children's Hospital to the third-year medical students.

Q. And where do those take place? How many days and hours a week?

A. The second-year medical students it's a series of four lectures given through their physiology core. The third year medical students, it's a pediatric core, and the neonatologists rotate through that core so whenever I'm up for the core, it's a series of five lectures that we have to give. It occurs about once a year.

Q. So one time a year you give the same lecture basically five times?

A. Not the same lecture, a series of lectures, but, yes.

Q. Over what time period? A day? A week?

A. A week.

Q. And your office here, we're at the Wexner Research Center; is that right?

A. Yes.

Q. And where is your office located?

A. Right across the hall, Room 310.

Q. And what staff do you have here?

A. I have two full-time laboratory technicians, one part-time laboratory technician who work for me off my grants, and I'm also responsible for two younger faculty members who are new to the research process. I'm mentoring them.

Q. And what specifically is the research that

you're doing at this time?

A. At the present time we are looking at the developmental physiology of receptors in the vascular system. We're looking at the development of the ability of the infant to control blood flow during fetal and postnatal life.

Q. Does this involve animal research?

A. Yes, it does.

Q. Is that done here?

A. Yes, it is.

Q. Is that your only research area at this time?

A. Yes.

Q. And how long has that been the case?

A. **15** years.

Q. And I noted in your CV that almost all of your publications deal with that subject matter in one way or another?

A. That's correct.

Q. You are not an obstetrician?

A. No, sir.

Q. Nor a gynecologist?

A. No, sir.

Q. And you don't treat patients with that specialty of medicine?

A. No, sir.

Q. The specific question that you were asked to pass upon in this case as an expert was to determine if the baby, Robert Paoloni, if the baby's presentation and course were consistent with that of an infant of a diabetic mother, correct?

A. Yes.

Q. You are not dealing with the condition of the mother as evaluated and treated by any obstetrician, are you?

A. No.

Q. So that regardless of what the opinions might be with respect to the mother, you're strictly focusing on the presentation of the infant, correct?

A. Not exactly. There are issues in this case regarding accuracy of certain tests and regarding modes of delivery, that while not being an obstetrician, I would have some opinion on. Specifically, one does not need to be an obstetrician to know about the accuracy of fetal ultrasonography at term. One has to be a physiatrist or know about ultrasound which I do.

From that context I would say that without necessarily providing an opinion regarding what this doctor did or didn't do, I would be able to provide an opinion regarding the accuracy of certain tests at certain times.

Q. You're saying that you are going to express an opinion in this case concerning the accuracy of ultrasound at term?

A. If I was asked, yes.

Q. And tell me what your experience is with ultrasonography of pregnant women at term?

A. In what context?

Q. Anything. Have you ever treated and had an ultrasound done of a patient like that?

A. No; but as I work at University Hospital with our perinatologists very closely involving myself with the patient as a fetus before the child is born, I am very aware of ultrasonographic techniques and what they're able to show and what they're not able to show. At University Hospital, I work very closely with the perinatologists when there are situations where my opinion from the standpoint of fetal physiology and newborn medicine might become necessary or appropriate.

Q. Is the accuracy of ultrasound dependent upon the time during the pregnancy that the test is done?

A. Yes.

Q. To some extent?

A. Yes.

Q. And why is that?

A. It's common sense. When the egg and sperm

unite, those cells are all the same size. They divide, divide, divide. During the first, roughly, 20 weeks of gestation, human embriologic growth is extremely standard unless there is significant genomic aberration, chromosome problems or maternal inspection. The standard deviations at 20 weeks' gestation is very small. That is why obstetricians are so able to pinpoint the gestational age of a fetus before the 20th week with an ultrasound because the femur length, et cetera, are very, very similar.

Q. What do you mean they're similar? Similar to what?

A. All fetuses are about the same. If the fetus is growing in a normal healthy uterus and has a normal complement of chromosomes and has not been invaded by an infecting virus or microbe, then the growth is very standard if all is well. Beginning at about 20 weeks gestation there is a very distinctive change in the rate of fetal growth. At that time the process of embriogenesis shifts from primarily developing organs to growing organs.

In other words, in the first 20 weeks you form the heart, you form the liver, you form the intestine, you form the brain. In the last 20 weeks you grow the heart, you grow the liver, you grow the intestine, you

growth the brain. That last 20 weeks has quite a bit of variability to it. As a consequence, fetuses at term have a fairly substantial variation in their birth weight. If you were to look at the weight of abortuses at 18 weeks' gestation, they would all weigh about the same, but obviously at birth they're all fairly substantially different.

The other reason that ultrasound becomes a problem later in gestation is because the amount of amniotic fluid around the child has become compressed or decreased because the child is becoming bigger. In other words, the ability of the ultrasonographer to measure things against a back drop of amniotic fluid has been compromised.

In this particular case, regarding this particular patient, you have one additional very important factor. This woman's pre-pregnancy weight was 260 pounds. That is morbid obesity. I'm 20 pounds over my ideal weight. I should lose it, my wife tells me. This woman at 5 feet 8 inches tall should weigh 131 pounds. She weighed 260 pounds. She was twice her normal weight. Women, unfortunately, gain that weight around the pelvis and the hips, which means that the ultrasound beam would have had to go through a very large pad of fat before it even hit the baby. The

accuracy of ultrasonography is clearly unequivocally compromised in obese patients. There is no question about that.

Q. But it had no effect upon the two ultrasounds that were taken at 20 and 25 weeks, I think it was?

A. You have no way of knowing that. How can you say that?

Q. Well, that's my question. Do you know?

A. The only way you would have been able to determine if the ultrasounds were accurate would have been to extricate the fetus at that time and compare your ultrasonographic measurements to the actual child's size, so there's no way of knowing.

Q. But they did, on both of those ultrasounds, the reports indicated that all the appropriate measurements were made?

A. Right.

Q. And they visualized the fetal anatomy?

A. Yes.

Q. The kidneys, the bowel, the chest, the heart, the spine, the face?

A. Correct.

Q. So that there wasn't any obstruction that apparently was significant. There was no report here that they had any problem because of her 260 pounds of

weight?

A. Yes.

Q. Or actually she weighed more than that when these were taken. Actually, they determined at the second ultrasound on December 19 at 25 weeks that the fetal weight was in the 72nd percentile, correct?

A. Correct.

Q. And there wasn't anything that said that they had any difficulty with the procedure or that it was inadequate in any way, correct?

A. Correct.

Q. And since no ultrasound was taken after that, we can't say what the results of that would have been, can we, with any degree of scientific or medical probability?

A. Correct.

Q. Are you familiar with the literature that talks about the accuracy of ultrasound in predicting weight at term?

A. Yes.

Q. Would you agree with me that there's generally an agreement that the deviation is plus or minus, in some cases, as wide as 10 to 20 percent?

A. Correct.

Q. So tell me in addition, do you have any other

opinions about ultrasound or any other tests since you mentioned testing and studies?

A. No.

Q. No?

A. No.

Q. That's the extent of your opinions on that subject?

A. Yes.

Q. And did you say you have other opinions about the obstetrical care of the patient?

A. I have two opinions: one, there has been concern raised in the depositions that I have read that the woman should have had a Caesarean section. Nowhere in these depositions, to at least my reading, is the point made that performing a Cesarean section on a 300 pound woman is a dangerous and potentially risky business. In other words, laypeople think that we just make a big hole and grab the child and out it comes. The fact of the matter is that I have seen obstetricians wrestle with large babies just as vigorously from above as from below. Performing a Cesarean section, anesthetizing a 300 pound pregnant woman is dangerous. You can do spinal anesthesia or an epidural which is going to be difficult to do possibly because of her size. There's a risk to her spinal cord. There's a

risk of wound dehiscence postoperatively. There's a risk of uterine damage because of her size. So I think that it's important, at least at some point, that it be made aware, that people be made aware that whereas Cesarean section is certainly something you might have considered here, that it's not to be looked upon as it would have saved the day. It's a difficult procedure to do in a 300 pound woman. Now, I have never done one. I have seen hundreds done. And I am sure that both your experts and anybody else you want to get who is an obstetrician will tell you that when they are confronted with a patient with morbid obesity, that they're not really anxious to be doing sections.

My second opinion is that in putting this whole case together, it kind of strikes me as odd that this physician is being vilified when what he did was save the child's life. He went into this operative delivery from below. Now, put apart, put away for a moment the issue of should she have been scanned because, quite frankly, she puts me on the stand and I'll convince a jury that the scan is plus or minus 20 percent and, therefore, he would not have known how big the child really was. There are papers out there, good papers and good journals that clearly state that the ability to assess fetal size by hand maneuvers is equal to that of

ultrasound at term. I have them not here, but I can produce them if given sufficient time.

This child is born, the head comes out, you have shoulder dystocia. This child nearly died. His one-minute Apgar score was zero. His five-minute Apgar score was two. If this physician had not done what he did, we would not be talking about a limp arm; we would be talking about a dead baby or a severely brain damaged baby.

If you come to me with a serious injury and say, "Doctor, I'm seriously injured."

And I say back to you, "I can save your life but I can't save your arm." What's your answer going to be? This guy, as far as I'm concerned, had a very obese mother, a very big baby, he knew it was big going in, but he didn't know how big and I don't think anybody could have known how big. He did the best he could. He got that baby out. If he had not done what he did, the child would have died or would have sustained massive brain damage.

Q. Okay. I appreciate your advocacy and your argument, Doctor, and so I want to discuss some of these with you. Who has the right to consent to the mode of delivery of the baby?

A. There is no right to consent.

Q. Who has the right to consent to surgery, any surgery by any physician?

A. The patient.

Q. The patient, correct. Do you know what this doctor discussed with the patient about the risks --

A. No.

Q. -- of this delivery?

A. No, I do not.

Q. Do you disagree with the obstetricians who have testified in this case regarding the right of the patient to be told the reasonable and appropriate risks of this pregnancy and of the delivery and of the mode of delivery?

A. Absolutely not.

Q. And if this patient would have been told about the risks and if she would have said to the doctor, "My husband and I have discussed this and we would like to have a C-section," and the doctor would have performed a C-section prior to the trial of labor, this baby probably wouldn't have had the arm that the baby had, right?

MS. DISILVIO: Objection.

MR. ALLISON: Objection.

A. You have no proof of that.

Q. You have no proof of the speculation that

you've been giving and arguing about either, do you?

MS. **DISILVIO**: Objection.

Q. Go ahead. She's just objecting for the record. You have to answer.

MS. **DISILVIO**: **I** want to make sure there's an objection noted to that previous question too.

A. **I** have obvious proof. Look into the eyes of the child. He is alive. He smiles at you.

Q. That's your proof?

A. Yes,

Q. I understand.

A. What more proof do you need?

Q. Proof that he would have a healthy arm would be nice, wouldn't it?

A. You have no way of knowing that.

Q. Nor do you?

A. Nor do I.

Q. Now, getting on to your opinions on the subject that you wrote on the appearance of this child, do you have anything in addition to the information contained in your report, anything else at all to say?

A. No. The child was clearly not an IDM. There is absolutely no question about that.

Q. There is no evidence whatsoever?

A. None whatsoever.

Q. Are there cases, Doctor, where babies of gestational diabetic mothers don't have any of the indicia that you've indicated are necessary to show that they are?

A. I'm sorry. I don't understand the question.

Q. Are there babies that are born whose mothers have had gestational diabetes who appear without any of the symptoms and signs and laboratory studies that you say are necessary as indicia of being born of a diabetic mother?

A. It's a function of the mother's glucose control during the last portion of pregnancy.

Q. Can you answer the question?

A. I'm answering the question.

Q. Okay. Is it true or not true?

A. That is not a yes or no question.

Q. Okay.

A. It's a function of the mother's glucose tolerance during the last trimester of pregnancy. If the mother is a gestational diabetic and if she is hyperglycemic during that last **12** weeks, **16** weeks, and the child would have been exposed to her glucose across the placenta, that would have stimulated the child's pancreas to produce insulin which would have caused the child to grow massively. So that you could have a

mother who has got gestational diabetes but who's well controlled or a mother who has insulin dependent diabetes pregestationally who is well controlled, whose glucose is well controlled during pregnancy, and, therefore, does not expose her fetus to hyperglycemia and the child will come out perfectly fine.

All of the problems with infants of diabetic mothers are the consequence of maternal hyperglycemia and the subsequent hyperinsulinism which the child produces.

Q. So it doesn't really matter how this child got to be 5400 grams, does it? This was a big baby?

A. You have to phrase the question more completely, I mean.

Q. Does it matter how this baby got to be 5400 grams?

A. To who?

Q. To the mother and to the obstetrician?

MS. DISILVIO: If you don't understand the question, Doctor, ask Mr. Lancione to rephrase it for you.

A. I mean, are you saying from the standpoint of what you would have done for the delivery? I think if the mother was a diabetic --

MS. DISILVIO: Hold on a second, Doctor. Don't

guess to what his question means.

MR. LANCIONE: He can answer the question if he wants to.

MS. DISILVIO: He is guessing as to what your question is.

Q. Are you guessing at my question?

THE WITNESS: No. I think I know what he's talking about.

MS. DISILVIO: All right.

A. Thank you. I think that most obstetricians would be very, very cautious about a large fetus who was in the womb of a mother who was a known diabetic because of the risk and fetal complications, and the postnatal complications to the baby. In other words, if you have a large, large baby, because of hyperinsulinism there's a lot of things that do happen to that child postnatally, and so under that circumstance the obstetrician might think of that in a somewhat different fashion.

Q. Do you know whether or not there is a standard for defining macrosomia?

A. Yes.

Q. What is it?

A. Macrosomia is defined in this country as a fetus that weighs more than roughly 4 kilograms.

Q. 4,000 grams?

A. Right.

Q. And do you recognize that there's any standard in obstetrics for a standard of care to be exercised by reasonably prudent physicians in the face of microsomia?

A. I'm not an obstetrician.

Q. Now, if you are going to testify that the range of error in ultrasound at term is 20 percent and base that testimony on literature rather than your own personal experience, are you going to do that?

A. That would be my only means to do it.

MS. DISILVIO: In all fairness, he doesn't know what he's going to be asked at the time of trial.

MR. LANCIONE: Well, I can ask him those questions certainly at this time, can't I?

MS. DISILVIO: Certainly.

MR. LANCIONE: Thank you.

A. I would have no other recourse but to use literature.

Q. The trial in this case is August 25th. I would like to have the literature, all of the literature that you claim supports that hypothesis.

A. Which hypothesis now, just so I'm sure.

Q. That the deviation from accuracy is 20 percent in ultrasound at term.

A. Well, you're the one stating 20 percent, not I. I'm only telling you that the accuracy decreases as you approach term and we can find that out.

Q. I misunderstood you. I thought you were going to say it was 20 percent deviations.

A. No, you used the No. 20.

Q. I said 10 to 20 percent.

A. You used the numbers. All I said was that there is less accuracy as you get towards term and we can certainly produce that. That's not a problem.

Q. Okay. I would like to have that within some reasonable period of time. Would ten days be adequate for you to send that to counsel?

A. No, I'm on service this month. I cannot get it to you until the second week of August. I will be away with my family on vacation in the first week of August. I do not have time to do library searches in July. I can do it when I come back from my vacation.

Q. And you'll have that by when? August what?

A. 15.

Q. Well, I would like it as soon as possible and as soon as you can get it to me, that will determine what I have to do. So are you going to express any opinions based upon reasonable medical probability that are critical of any of the experts that have testified

in this case, critical of any of their opinions?

A. Yes.

Q. And whose opinions are you going to be critical of?

A. Dr. Gim --

MS. DISILVIO: Gimovsky.

A. Gimovsky. I should be able to pronounce that. I'm Polish myself.

Q. What opinions of his are you going to challenge?

A. In his deposition he claims that the child was an infant of a diabetic mother because the head circumference was small, the body was large and because the child was hypoglycemic, and both are untrue or both are incorrect.

Q. Did you mark that page?

A. Yeah. This is the No. 38 centimeter head circumference, if you look at the picture here.

Q. Yes.

A. All babies that are born in this country have these data plotted out at the day of their birth. Head circumference, length, weight. Initially when this child was taped out they plotted it down here, but that was an error. The head circumference was **38** centimeters. The normal head circumference is **33.5**

centimeters. This child is well above the 98 percentile. He claimed it was 75th. I think what he did was look at that and plot in error.

Q. The copy he has was so dark.

A. Right. I'm sure that was the reason.

Q. But the 75 was plotted and Xed over, obviously.

A. Yes, because the measurement is right here and the child's admitting history and his physical at 38 centimeters, which means that the child did not have the classic physiognomy of an IDM having a large body and a small head. He had a large body and a large head. He was just a macrosomic infant.

Q. Macrosomic?

A. Yes, a big kid. The other opinion that he had was the child became hypoglycemic at birth. He's right, but he's also wrong. This number that I've related here is 64. Bobby was born at 1:28 in the morning. Now, he was very depressed at birth and the doctor did a beautiful job. This child received magnificant care at this hospital. The parents should send them flowers every year. They saved this child's life beautifully. They gave the child -- they placed an umbilical venous catheter during the child's immediate post birth period, but what they gave was normal saline. Normal saline has no glucose in it at all. There is a dextrose stick done

at 2:01, 33 minutes after the child was born.

Infants of diabetic mothers, especially ones that would be this big, as a consequence of their hyperinsulinism are going to have a very, very rapid and sharp drop in their glucose within 30 minutes of birth. This child had received no glucose at all but it had been stressed incredibly by this difficult delivery; yet was still able to maintain a glucose in the normal range. That is completely incompatible with being an IDM. The hypoglycemia that he experienced was at 6 hours of age, and that was just a matter of the nursing staff and the attending neonatologist adjusting his fluids and adjusting his fluid administration. They had decreased his fluids because we do that routinely in asphyxiated babies so they don't get water overloaded, and when that happens the dextrose concentration that was being given was decreased so he became transiently hypoglycemic and he responded perfectly to a very small push of glucose; and in a diabetic mother, a baby who weighs 5.5 kilos at birth and whose macrosomia is the consequence of hyperinsulinism is going to have to get at least 25 milligrams per kilogram per minute of glucose from birth onward to maintain a normal blood sugar. Bobby only received 5 milligrams per kilogram per minute beginning one hour after he was born. And

the only time he was hypoglycemic was when the nurses cut his I.V. rates back transiently to make sure he wasn't gaining too much weight. It's completely, completely incompatible with being an IDM.

Q. So you disagree with Dr. Gimovsky's conclusion that this lady was an overt diabetic?

A. No. What I'm saying is not that this mother was a gestational diabetic. What I'm saying is that Bobby was not an IDM unequivocally. There's absolutely no doubt that this child's macrosomia was related to hyperinsulinism. It was not.

Q. So she may have been carbohydrate intolerant, she may have been an overt diabetic but that did not result in this child being a **5400** gram baby?

A. The reason that she grew a very large child is known but to God. I mean the fact is that there are some people out there that grow very, very big babies and we don't know why. That has nothing to do with hyperinsulinism.

Q. And that usually is something that occurs in families, isn't it?

A. It can be, but not necessarily so.

Q. And you speculate that the father was large too in this case, in your report, don't you?

A. Well, the mother, as women go, is a large

woman.

Q. And you said "I suspect a large father"?

A. He probably is. Is he?

Q. Depends upon what you classify as large.

A. Is he bigger than me? I'm 6 feet, 200 pounds. I consider myself just above the norm for an American male.

Q. You'd expect a large --

A. I'd expect 6-2, 6-3.

Q. 220? 240?

A. Yeah.

Q. You don't know anything about the maternal birth weight in this case, do you?

A. I'm sorry, the what?

Q. Maternal, the mother's birth weight?

A. No, I do not.

Q. The birth weight of her siblings?

A. No, I do not.

Q. Or the birth weight of the baby's, if there's siblings?

A. No, I do not.

Q. And you're not an obstetrician so you wouldn't have any opinion as to whether or not an obstetrician should know those kinds of things on a patient that's 38 years old, an elliperous patient?

A. That's correct.

Q. Weighing 260 pounds?

A. I don't practice obstetrics, I agree.

Q. What about Dr. Landon, what of his opinions do you have criticism of?

A. None.

Q. And tell me about your publications in the field of gestational diabetes and infants of gestational diabetic mothers.

A. I have none.

Q. And how many -- you said you review four to five cases a year?

A. Correct.

Q. And that's been true for how many years?

A. About four to five. I began this about seven years ago, but it really picked up steam about four to five years ago.

Q. And how many depositions do you give in a year, usually?

A. Probably about three to four.

Q. And where are those given? Here?

A. Here.

Q. And have you testified in court before?

A. Yes, once.

Q. Where?

A. Huron County.

Q. On behalf of whom?

A. On behalf of the Defendant.

Q. And what was the nature of that case?

A. It was a case involving a child. The mother came in at 34 weeks' gestation. She was in labor. She had ruptured her membranes. The obstetrician began Pitocin and had a labor of 36 hours, and the child was born profoundly depressed. The family practice doctor in the delivery room did the best he could to help the child. By the time the child was born, the child had already taken a major hit and I was defending the pediatrician basically saying that he had done a good job and that the problem that had occurred with the child had occurred before the child had been delivered.

Q. Who were the attorneys that were representing or that you were working for?

A. Beverly Sandacz.

Q. Out of?

A. Reminger & Reminger.

Q. How many other cases have you consulted for with the Reminger law firm?

A. I think one but I'm not sure. I know at least one, at least one.

Q. What was that?

A. I don't remember. I don't keep records of this.

Q. Who was the lawyer?

A. I don't remember. I don't keep records of this stuff. Once the case is done, it goes into the circular file.

Q. Prior to that, you do keep a record of your time that you spent?

A. Yes.

Q. And the amount you bill out and you keep a record of what you're paid?

A. Yes.

Q. What other law firms have you consulted with in the Cleveland area?

A. I can't -- I've worked for a firm in Jacksonville, Florida; I have worked for a firm, it was Jaworski, something and Jaworski down in Houston, Texas; Lord, Bissell & Brook from Chicago, and that's the ones that I remember because they have nice stationary.

Q. They're all firms that represent doctors rather than patients?

A. I have done work for both Plaintiffs and doctors.

Q. Tell me about the Plaintiffs' cases that you worked on.

A. I have done at least two Plaintiffs' cases that I can remember. They were several years ago. One was a child that had been born who had an infection at birth and the child was, the case was -- the alleged misconduct was on the part of the pediatrician who had not recognized the symptoms of sepsis early enough, and the other was for an obstetrician, was a case of proximate cause. He suspected brain damage, and allowed a woman to labor with late decelerations and no fetal variability for a sustained period of time and I was asked to testify regarding when the injury was caused.

Q. Other than those two Plaintiffs' cases, have you testified or offered opinions in support of the patient in any other cases?

A. No, but I'm always willing to do so. When the phone rings, I answer it and I would always be willing to review a case. My comment to the lawyer is always simply this: "Just send me the information. I'll look at it. If I think the case has merit in what you're looking for, I will tell you if I can help you. If not, I will tell you I can't." If a Plaintiff's lawyer called me today, I would have no problem doing a Plaintiff's case. Malpractice happens, there's no question about that, and as far as I'm concerned, I would have no difficulty in assisting a Plaintiff in

redeeming compensation when malpractice has occurred, absolutely none.

Q. What is your definition of malpractice?

A. A malpractice would be when a physician clearly falls below standard of care primarily by means of negligence, by not doing enough or by not paying close enough attention to the details, by making assumptions, and by not obtaining the kind of information that would be necessary to truly help him make a decision one way or the other, or by not rendering care in a timely fashion.

Q. In addition to cases in Florida, Texas, Illinois and Ohio, what other states have you testified in or given testimony?

A. I don't remember. I think there was one in New Mexico many years ago and I think there was one in Oregon but you're taxing my memory. I really don't keep records of this stuff.

Q. And what do you charge for your professional services, Doctor?

A. $200 an hour to review a case, $300 an hour to prepare a report, $300 an hour for a deposition, $500 an hour for trial, plus there would be fees regarding trial preparation and getting to and from the trial. I'm told I work cheap.

Q. The only question I have, Doctor, is what kind of flowers you would recommend this family send to Dr. Haftkowycz?

A. It wasn't to Dr. Haftkowycz; it was to the Fairfield County Medical Center.

Q. Fairview?

A. Fairview. This child's newborn care was absolutely outstanding. I have never read a chart that is so well presented. These guys should --

Q. Newborn care?

A. Yeah. These guys should advertise and teach people how to write progress notes and record things in the chart. It was marvelous, absolutely outstanding. They did everything they should have done.

Q. You're not -- I understand what you're saying, Doctor. You don't have to repeat it for me.

MR. ALLISON: I kind of enjoyed it.

MR. LANCIONE: Well, hey, be my guest.

Q. You weren't suggesting that they send Dr. Haftkowycz flowers, though?

A. I think --

Q. Did you think they should do that too?

MS. DISILVIO: Objection.

A. No.

Q. Do you have any opinion as to whether or not

the nurses at Fairview General that were attending during the delivery of this patient, the baby, exercised appropriate standard of care?

MR. ALLISON: Objection.

A. I have no opinion.

MR. LANCIONE: That's all I have.

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EXAMINATION

By Mr. Allison:

Q. Doctor, my name is Tom Allison. We met right before your deposition and I just have a couple questions for you. First, Mr. Lancione had asked you about one of the comments that you made in your report with respect that you suspected that perhaps Mr. Paoloni was a large man. You have never seen Mr. Paoloni; is that right?

A. No, sir, I have not.

Q. If, in fact, he's not a large man, if he's just average built, say he's 5-9 and medium build, does that have any effect whatsoever on your opinions in this case as you expressed them today?

A. No.

Q. You've indicated a couple times that you believe that the care that Bobby Paoloni received after his birth at Fairview Hospital was, I think you have

used the words, outstanding and marvelous and magnificant. Those opinions, Doctor, are consistent with the specifics of the newborn care as set forth in your report, correct?

A. Yes, sir.

Q. And you still hold those same opinions regarding his newborn care that's set forth in your report, correct?

A. Yes, sir.

MR. ALLISON: Thanks, Doctor. That's all I have.

MS. DISILVIO: Thank you very much. We'll read it.

- - -

State of Ohio

County of Franklin :

I, Philip T. Nowicki, M.D., certify that I have read the foregoing transcript of my deposition given on July 21, 1998; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

_____
Philip T. Nowicki, M.D.

I do hereby certify that the foregoing transcript of the deposition of Philip T. Nowicki, M.D., submitted to the witness for reading and signing; that after she had stated to the undersigned Notary Public that she had read and examined her examination under oath, she signed the same in my presence on the _____day of _____, 1998.

_____
Notary Public

My commission expires: _____

- - -

CERTIFICATE

State of Ohio
ss:
County of Franklin :

I, Iris I. Munsell, Notary Public in and for the State of Ohio, duly commissioned and qualified, certify that the within named Philip T. Nowicki was duly sworn or affirmed to testify to the whole truth in the cause aforesaid; that the testimony was taken down by me in stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony given by said witness taken at the time and place in the foregoing caption specified.

I certify that I am not a relative, employee, or attorney of any of the parties hereto, or of any attorney or counsel employed by the parties, or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 24th day of July, 1998.

Iris I. Munsell, Notary Public
in and for the State of Ohio, and
Registered Professional Reporter.

My Commission Expires February 5, 2003.

- - -

ARMSTRONG & OKEY, INC.
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July 27, 1998

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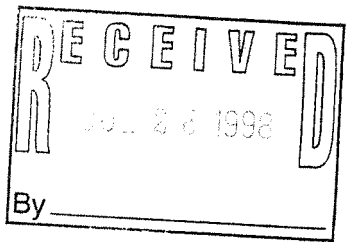

Paoloni vs. Haftkowycz

Dear Dr. Nowicki:

Enclosed is the transcript of your deposition taken on July 21, 1998, for examination pursuant to Rule 30(E) of the Ohio Rules of Civil Procedure.

The rule requires that your deposition be read by or to you. Any changes in form or substance which you desire to make shall be listed on the errata sheet with a statement of the reasons given for making them.

If your deposition is not signed within 7 days of its submission to you, I am required to sign it and state the fact of the refusal to sign with the reason, if any, given therefor; and the deposition may then be used as though signed, unless on a motion to suppress to the court holds that the reasons given for the refusal to sign require rejection of the deposition in whole or in part.

By copy of this letter I am advising the attorneys in the case of the submission of your deposition.

Please have your deposition signed in the presence of a Notary Public and return to me by certified mail.

Thank you for your promptness in this matter.

Sincerely,

Iris I. Munsell, Registered Professional Reporter.

cc: J. Lancione
T. Allison
M. DiSilvio